Hospital and
Ambulatory Surgical Center
Payment Manual

Effective July 1, 1997

South Carolina
Workers= Compensation Commission
SOUTH CAROLINA
WORKERS= COMPENSATION COMMISSION

HOSPITAL AND AMBULATORY SURGICAL CENTER PAYMENT MANUAL

CONTENTS

Hospital and Ambulatory Surgical Center Payment Manual

A. OVERVIEW

The 1997 South Carolina Workers' Compensation Commission's Hospital and Ambulatory Surgical Center Payment Manual contains the policy governing the billing and payment of hospitals and ambulatory surgical centers for services rendered under the Workers= Compensation Act, and a listing of those DRG classifications and payment rates most relevant to workers= compensation. The payment rates listed herein are deemed by the Commission to be fair and reasonable and were developed under the statutory and regulatory authority provided by Title 42 of the Code of Laws of South Carolina, 1976, as amended, and Chapter 67, Article 13 of the Regulations of the Workers= Compensation Commission.

These payments were created based on the recommendations of the Hospital Advisory Committee appointed by the Commission in March 1995. The Committee was charged with reviewing and recommending improvements to the existing hospital payment system and to make recommendations for establishing an outpatient fee schedule. The fifteen member Advisory Committee, chaired by Commissioner W. Lee Catoe, was composed of representatives of the hospital industry, medical association, property and casualty insurance carriers, a health insurance carrier, a self-insured fund, business and industry as well as state government.

With the development and adoption by the Commission of a new physician fee schedule in late 1994 and early 1995, creation of the Advisory Committee was an important step in the continuation of the Commission=s efforts to assure that workers= compensation fee schedules adequately pay for services provided, ensure access for workers= compensation patients and contain costs for business and industry. The Advisory Committee met seven times over an eighteen month period between May 15, 1995 and September 27, 1996 to review the current system, delineate and review the analysis conducted, and to develop recommendations.

After careful consideration of alternative payment systems, the committee focused on a DRG payment system and began establishing the parameters for setting rates for the workers= compensation program. After further data analysis and discussion, the committee proposed that the Commission adopt a DRG payment system with rates set based on a 12.1% overall discount from charges and statistically defined outliers to identify and appropriately pay for extreme cases which would either be under- or over- paid by a standard DRG rate. Two DRGs, Psychoses and Rehabilitation, will be paid by individual statewide per diem rates since there are wide variations in charges and lengths of stay. Rates will be in effect for two years, resulting in a greater discount from charge during the second year as the cost of providing services increases over time.

Diagnosis Related Groups is a classification system which sorts inpatient claims into one of 495

groups or classifications. Each hospital discharge can be assigned to a DRG group based on the diagnoses, procedures performed, complications, comorbidities (pre-existing conditions), signs and symptoms and discharge status. A DRG payment system is prospective in nature in that the price is set prior to the services being rendered. Payment is based on the diagnosis related group the claim is assigned and determined by the resource needs of the average patient for that diagnosis group. Also included in this determination is length of stay and intensity of services. Patients within a given diagnosis related group will demonstrate similar resource consumption and length of stay patterns.

The Committee adopted a DRG payment system with relatively tight parameters. That is, for low and high cost claims, different provisions are made. Without such provisions, the DRG payment, which is based on an average, would not be appropriate; low cost claims would be overpaid and high cost claims would be underpaid.

The Commission also charged the Hospital Advisory Committee to make recommendations regarding the establishment of an outpatient fee schedule. The Committee reviewed outpatient payment methods currently being used by other states for workers= compensation programs. The Committee also reviewed the outpatient prospective payment system developed for Medicare and currently under consideration by Congress on the recommendation of the Health Care Financing Administration (HCFA). This system, Ambulatory Patient Groups, APGs, is similar to DRGs in that it is a prospective payment system. It is a classification system that groups claims which are similar in nature, claims which have similar clinical characteristics and are similar in the kind and amount of resources that will be necessary, on average, to treat the case. This system, like DRGs, moves away from a charge-based system to a case-based payment and is being used by some major insurance carriers and state Medicaid programs.

APGs require that all outpatient bills use Common Procedural Terminology (CPT) Codes. Currently all hospital outpatient claims are billed according to International Classification of Disease (ICD-9) codes. The change in billing requirements is significant. Since workers= compensation claims comprise a small percent of the outpatient market, the Committee did not recommend the adoption of APGs for an outpatient payment system. However, members of the Committee were impressed with the system: it has the same advantages as a DRG system and moves away from a charge-based system. Since it appears that Medicare will adopt the APG system in the near future, the Committee recommended that the Commission reconsider APGs once it is adopted by Medicare. Because of the need for an outpatient payment system, the Committee has recommended an interim system based on a discount from charge.

B. GENERAL POLICY

Effective Date

The policies and payments listed in this manual are effective as of July 1, 1997. Any claim for services rendered on or after July 1, 1997 is subject to the payment methodologies described herein. For the purpose of determining payment, the date of service for an inpatient hospital stay is the date of admission. Therefore, a claim for a hospital stay with a date of admission prior to July 1, 1997 would be made according to the Commission=s 1997 Per Diem Rate List, and would *not* be paid according to the rates listed herein, even if the date of discharge is after July 1, 1997.

Authorization to Treat

Health care providers must receive authorization from the employer or insurance carrier prior to providing treatment, except for emergency care when the carrier cannot be reached. When an employer authorizes treatment, whether verbally or in writing, the employer assumes liability for paying for that service, even if it is determined later that the injury was not work-related. Whenever possible, providers should obtain written authorization from the employer. Providers may request the employer to fax a written authorization at the time authorization is given. If it is not possible to obtain written authorization, the provider must document the authorization by noting the date and time of the authorization and the name of the individual who authorized treatment. Verifying that the employer has workers' compensation coverage is not authorization to treat.

Medical Services Rendered in Another State

The payment rates listed in this manual are not applicable to medical services rendered outside of the state of South Carolina even when the services are provided under the South Carolina Workers' Compensation Act. Therefore, insurers and self-insureds should inquire about and negotiate rates with out-of-state providers prior to authorizing care.

Out-of-State Injuries or Work-Related Illnesses Treated in South Carolina

It is possible that an individual may receive medical services in South Carolina for injuries

incurred in an accident under the jurisdiction of another state's workers' compensation act. In this case, the policy and procedures listed herein would not apply. However, when a worker receives medical services in South Carolina pursuant to the South Carolina Act, the payment is subject to the policy listed in this document regardless of the site of injury. Providers may contact the payor to determine whether benefits are being provided pursuant to South Carolina law or the laws of another state.

Submitting Claims for Payment

The Commission does not pay health care providers. Insurance companies, self-insurance funds, or self-insured employers providing workers' compensation coverage are directly responsible for issuing payments to authorized providers. Providers must submit claim forms to the employer or insurance carrier for payment. A provider who is unsure who the insurance carrier is may contact either the employer or the Commission's Division of Coverage and Compliance at 803-737-5704. To avoid unnecessary delays in receiving payment, please do not send claim forms to the Commission for payment.

Collecting Payment

To determine the status of an unpaid claim, contact the employer or insurance carrier. A provider who is unsure who the insurance carrier is may contact either the employer or the Commission's Division of Coverage and Compliance at 803-737-5704.

The Medical Services Division can, within the scope of its jurisdiction, provide assistance to providers who are unable to collect payments from employers or insurance carriers. To request assistance, submit to the Medical Services Division a cover letter explaining the situation and the steps taken to collect payment, along with a copy of the claim, evidence that the service was authorized, and any supporting documentation. If the employer/carrier fails to make payment after being contacted by the Division, the provider may then pursue payment through standard collection methods.

"Balance Billing" and Collection Procedures Against the Claimant

Medical providers will be paid for authorized services at the rates specified in this document. If a provider's charge is greater than the amount approved by the Commission, the provider must *not* bill the patient or the employer for the difference, pursuant to Section 42-15-90.

It is unlawful for a medical provider to actively pursue collection procedures against a workers= compensation claimant prior to the final adjudication of the claimant=s claim. A medical provider who violates this regulation after receiving written notice from the claimant or the claimant=s attorney is guilty of a misdemeanor and may be fined up to $500, payable to the claimant (see page 13, Section 42-9-360).

Copies of Records and Reports

Providers must submit copies of records and reports to insurance carriers, claimants or their attorney, or the Commission, upon request. Providers may *not* charge for supplying documents when such documents are requested by the Commission or when supplying an initial copy to the reviewer/payor for the purpose of substantiating charges and/or medical necessity. (See page 14, Section 42-15-95, and page 15, Regulations 67-1301 and 67-1303).

In those instances where a charge is allowed, the maximum charge for providing records and reports is $15 clerical fee plus 65**4** per page for the first thirty pages, and 50**4** per page for each page over thirty, plus sales tax and actual cost for postage to mail the documents.

Providers who use a medical records company to make and provide copies of medical records must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate charges and/or medical necessity.

NOTE: Providers do *not* need to obtain authorization from the injured worker to release to any party to a workers= compensation claim the medical records relating to a workers= compensation injury or illness. (See page 13, Section 42-15-80.)

Claims Review

All claims for payment of medical services rendered under the Workers' Compensation Act must be reviewed prior to payment to ensure that the services rendered were reported accurately on the claim form and that payment is made according to the policies and payments outlined in this document. The Commission requires insurance carriers, self-insured employers and third party administrators to become approved by the Commission to conduct claims review. Parties interested in becoming approved reviewers should contact the Medical Services Division.

For inpatient hospital claims only, reviewers/payors who are not equipped to process claims

for DRG classification may submit claims to the Commission=s Medical Services Division for review. Claims should be marked AFOR APPROVAL@ and must include the seven-digit workers= compensation claim number and the carrier code number. Submit claims for review to:

Medical Services Division
South Carolina Workers= Compensation Commission
Post Office Box 1715
Columbia, SC 29202-1715

A provider who has a question regarding a payment or reduction should write or call the party that reviewed the claim prior to contacting the Commission. If the matter cannot be resolved by contacting the reviewer, submit the claim and any documentation to the South Carolina Workers' Compensation Commission Medical Services Division for review. (See page 7, ADisputed Payments.@)

Timeliness

Payment to authorized medical providers must be made within thirty (30) days of the request for payment, pursuant to Section 42-9-360. Exceptions to the thirty day requirement may be made when the bill has been submitted to the Commission for review, or when documentation necessary to the bill review was not submitted with the claim and must be requested from the provider. In cases where documentation must be requested from the provider, payment must be made within 30 days of receipt of the requested information.

Explanation of Benefits (EOB)

The Commission and entities approved by the Commission may review and reduce provider charges to coincide with the guidelines and payment rates described in this document. When issuing payment to a provider, the reviewer/payor must include an Explanation of Benefits (EOB). The EOB must explain why the charge(s) has been reduced or disallowed. If the reviewer/payor uses codes to explain the adjustment, it must furnish the provider with a written explanation of each code used. The EOB must also include appropriate identifying information so the provider can relate a specific payment to the applicable claimant, the procedure billed and the date of service.

All EOBs must include a notice informing providers of their right to request an administrative review by the Commission's Medical Services Division in case of a disputed payment that cannot be

resolved by contacting the reviewer/payor.

Disputed Payments

When a provider disagrees with a review and payment for any service, the provider may make a written request for reconsideration **to the reviewer/payor** within 60 days from receipt of the EOB. The request must include a copy of the claim in question, the EOB and any supporting documentation to substantiate the charge/service in question. A dispute must be based on extenuating circumstances involved in the case or the provider=s belief that the review was not in accordance with Commission policy.

Upon receipt of a request for reconsideration, the reviewer/payor must review and re-evaluate the original bill and accompanying documentation, using a medical consultant if necessary, and respond to the provider within 30 days of the date of receipt. The payor's response to the provider must explain the reason(s) behind the decision and cite the specific policy upon which the final adjustment was made.

If the provider finds the result of the reviewer/payor's reconsideration unsatisfactory, that provider may then request an administrative review by the Commission=s Medical Services Division. Providers may send a written request for resolution of a disputed payment to the Division within 60 days of the payor's reconsideration, or 90 days from the date of the original request for reconsideration when the payor has not responded. A request for resolution of a disputed payment must include the following:

1) Copies of the original and resubmitted bills;

2) Copies of the EOB;

3) Copies of any supporting documentation;

4) Copies of correspondence and/or specific information regarding contact with the payor.

The Division will review the information, make a determination and provide written notification of its decision to both the provider and the payor within 30 days of receipt. Send requests to resolve a dispute to:

Medical Services Division

South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, SC 29202-1715

The Commission's review and determination is final.

C. PAYMENT POLICY

Outpatient Hospital Services and Ambulatory Surgical Centers

Services performed on an outpatient basis at a hospital or ASC are not subject to the DRG classification and payment methodology. These services are paid by discounting the total charge by 12.1%. A database of statewide or regional usual and customary charges must *not* be used to calculate payments for outpatient hospital or ASC services. The 12.1% discount is calculated by multiplying the total charge by .879. Always round to the nearest dollar when calculating payments.

Example:

For a claim with charges totaling $2,332 the calculation would be

$2,332 x .879 = $2,050

Outpatient Observation

A claim for outpatient observation will be paid as an outpatient claim when the patient is held in observation for up to, but not to exceed, forty-eight (48) hours. After forty-eight hours the claim will be paid according to the DRG classification and payment methodology regardless of whether the patient was formally admitted as an inpatient. The DRG classification and payment system is described on pages 9 through 11.

Inpatient Hospital Services

When a patient is admitted to the hospital as an inpatient, or remains in observation for more than forty-eight (48) hours, the claim will be paid as an inpatient claim according to the DRG classification and payment methodology. The DRG classifications are those developed by the Health Care Financing Administration (HCFA) for the Medicare program. A listing of the DRG classifications most relevant to workers' compensation is found on pages 17 through 28 in this document. Determining

payment for these claims is described in detail on pages 9 through 11.

Two DRGs, Psychoses (DRG 430), and Rehabilitation (DRG 462), do not have assigned DRG payment rates. Because the length of stay and intensity of services for these two DRGs can vary greatly from case to case, payment will be made according to the per diem rates described on pages 11 and 12.

D. DETERMINING PAYMENT FOR INPATIENT HOSPITAL CLAIMS

Assigning a DRG Classification

Each claim for inpatient hospital services, as defined in the previous section, must be assigned a DRG classification. This is achieved by means of a DRG grouper. The grouper uses vital information from the claim, such as diagnosis and charge information, to determine which DRG classification best describes the inpatient stay. Only a HCFA-DRG grouper may be used to classify workers= compensation claims for payment. Once a DRG is assigned to the claim, payment can be determined.

A hospital must assign a DRG classification to the claim prior to submitting it for payment. The DRG must be listed in form locator (field) 11 on the UB-92 claim form. Upon receipt of the claim, the reviewer/payor must process the claim to verify the DRG classification assigned by the hospital. A reviewer/payor who does not possess a HCFA-DRG grouper may submit claims to the Commission=s Medical Services Division for review (see page 5, ÁClaims Review@).

If the reviewer/payor processes a claim and arrives at a DRG classification other than the one assigned by the hospital, the reviewer/payor must forward the claim to the Commission=s Medical Services Division for review. The Medical Services Division will process the claim and determine the appropriate DRG classification.

Determining Payment

After the claim has been assigned a DRG classification, as described above, payment is then determined. Not all inpatient claims will be paid at the DRG payment rate. The workers= compensation DRG payment system takes into account that within any given DRG classification there likely will be claims with total charges that are unusually high or unusually low. Payment for these unusual claims will not be made at the DRG payment rate, but according to the methodologies described later in this section. Additionally, DRGs 430, Psychoses, and 462, Rehabilitation, do not have assigned DRG payment rates but are paid according to the per diem methodology described on pages 11 and 12. If you have any questions regarding payments, please call the Medical Services Division at 803-737-5741.

Pages 17 through 28 of this manual include a listing of selected DRGs. Each DRG included in this manual was chosen after careful consideration of the likelihood that the DRG would occur as a workers= compensation illness or injury. Those DRGs which were deemed unlikely to occur as a workers= compensation illness or injury were excluded. The inclusion or exclusion of a DRG classification does not imply coverage or non-coverage under the Workers= Compensation Act. In the event that a reviewer processes a claim with a DRG not listed in this manual, that reviewer must contact the Medical Services Division by calling 803-737-5741. If no DRG rate exists for that DRG, the payment will be determined by discounting the total charge by 12.1%.

Except for DRGs 430 and 462, each DRG has a designated DRG payment rate as well as a high trim point and a low trim point. Trim points are set at statistically defined intervals and, as the name implies, serve to exclude outlier claims with total charges that are unusually high or low. The DRG payment rate is applied to those claims with total charges falling between the high and low trim points.

Example:

> DRG 215: Back and neck procedures without complications and comorbidities
> Low Trim: $7,268 High Trim: $11,903 Rate: $8,911
>
> Total Charge = $9,012
> Because the total charge falls between the low trim amount and the high trim amount, payment will be made at the DRG Rate, $8,911
>
> **Note**: Any claim in DRG classification 215 whose total charge is not lower than $7,268 or higher than $11,903 will be paid at the DRG rate, $8,911.

A claim whose total charges are less than the low trim amount is considered a low-lier claim and one whose total charges exceed the high trim amount is considered a high-lier claim. Low-lier and high-lier claims are not paid at the DRG payment rate.

Determining Payment for a Low-Lier Claim

A low-lier claim is any claim with total charges less than the low trim amount for its assigned DRG classification. These claims must not be paid at the DRG payment amount. Payment is determined by multiplying the actual total charge by .879 to achieve a 12.1% discount. Always round

to the nearest dollar when calculating payments.

Example:

DRG 215: Back and neck procedures without complications and comorbidities
Low Trim: $7,268 High Trim: $11,903 Rate: $8,911

Total Charge = $6,220
Because the total charge is lower than the low trim amount, payment is determined by applying the low-lier calculation: $6220 x .879 = $5,467

Note: Payment for any claim in DRG classification 215 whose total charges are lower than $7,268 will be calculated according to this methodology.

Determining Payment for a High-Lier Claim

A high-lier claim is any claim with total charges greater than the high trim point for its assigned DRG classification. These claims are not paid at the DRG payment rate. Payment for high-lier claims is calculated according to the following methodology, DRG Rate + ((Total charge - high trim amount) x .96). Always round to the nearest dollar when calculating payments.

Example:

DRG 215: Back and neck procedures without complications and comorbidities
Low Trim: $7,268 High Trim: $11,903 Rate: $8,911

Total Charge = $15,920
Because the total charge is greater than the high trim amount, payment is determined by applying the high-lier calculation: $8,911 + (($15,920 - $11,903) x .96) = $12,767

Note: Payment for any claim in DRG classification 215 whose total charge is higher than $11,903 will be calculated according to this methodology.

Per Diem Rates

As described earlier, DRGs 430 and 462 have not been assigned DRG rates and are excluded

from payment under the methodologies previously discussed. Instead, a per diem rate has been set for each of these DRG classifications. Once the DRG classification is assigned, payment is determined by multiplying the per diem rate by the number of days of the inpatient stay.

Example:

DRG 430 Psychoses Rate: $956 per day

DRG 462 Rehabilitation Rate: $796 per day

1) To determine payment for DRG 430 Psychoses where the length of stay is 9 days, multiply the per diem rate for DRG 430 by the number of days of the stay:
$956 x 9 = $8,604

2) To determine payment for DRG 462 Rehabilitation where the length of stay is 6 days, multiply the per diem rate for DRG 462 by the number of days of the stay:
$796 x 6 = $4,776

E. WORKERS= COMPENSATION MEDICAL LAWS AND REGULATIONS

The following laws and regulations are excerpted from Title 42 of the Code of Laws of South Carolina, 1976, as amended.

42-9-360. Assignment of compensation; exemptions from claims of creditors and taxes.

(A) No claim for compensation under this title shall be assignable and all compensation and claims therefor shall be exempt from all claims of creditors and from taxes.

(B) It shall be unlawful for an authorized health care provider to actively pursue collection procedures against a workers= compensation claimant prior to the final adjudication of the claimant=s claim. Nothing in this section shall be construed to prohibit the collection from and demand for collection from a workers= compensation insurance carrier or self-insured employer. Violation of this section, after written notice to the provider from the claimant or his representative that adjudication is ongoing, shall result in a penalty of five hundred dollars payable to the workers= compensation claimant.

(C) Any person who receives any fee or other consideration or any gratuity on account of services so rendered, unless consideration or gratuity is approved by the commission or the court, or who makes it a business to solicit employment for a lawyer or for himself in respect of any claim or award for compensation is guilty of a misdemeanor and, upon conviction, must, for each offense, be fined not more than five hundred dollars or imprisoned not more than one year, or both.

(D) Payment to an authorized heath care provider for services shall be made in a timely manner but no later than thirty days from the date the authorized health care provider tenders request for payment to the employer=s representative, unless the commission has received a request to review the medical bill.

42-15-80. Physical examinations; facts learned by doctors are not privileged; refusal to submit to examination; autopsy.

After an injury and so long as he claims compensation, the employee, if so requested by his employer or ordered by the Commission, shall submit himself to examination, at reasonable times and places, by a duly qualified physician or surgeon designated and paid by the employer or the Commission. The employee shall have the right to have present at such examination any duly qualified physician or surgeon provided and paid by him. No fact communicated to or otherwise learned by any physician or surgeon who may have attended or examined the employee, or who may have been

present at any examination, shall be privileged, either in hearings provided for by this Title or any action at law brought to recover damages against any employer who may have accepted the compensation provisions of this Title. If the employee refuses to submit himself to or in any way obstructs such examination requested by and provided for by the employer, his right to compensation and his right to take or prosecute any proceedings under this Title shall be suspended until such refusal or objection ceases and no compensation shall at any time be payable for the period of suspension unless in the opinion of the Commission the circumstances justify the refusal or obstruction. The employer or the Commission may in any case of death require an autopsy at the expense of the person requesting it.

42-15-90. Fees of attorneys and physicians and hospital charges shall be approved by the Commission.

Fees for attorneys and physicians and charges of hospitals for services under this title shall be subject to the approval of the Commission; but no physician or hospital shall be entitled to collect fees from an employer or insurance carrier until he has made the reports required by the Commission in connection with the case.

Any person who receives any fee or other consideration or any gratuity on account of services so rendered, unless such consideration or gratuity is approved by the Commission or such court or who makes it a business to solicit employment for a lawyer or for himself in respect of any claim or award for compensation shall be guilty of a misdemeanor and, upon conviction thereof, shall, for each offense, be punished by a fine of not more than five hundred dollars or by imprisonment not to exceed one year, or by both such fine and imprisonment.

42-15-95. Disclosure of existing information compiled by treatment facility. [From and after July 14, 1994, this section reads as follows:]

All existing information compiled by a health care facility, as defined in Section 44-17-130, or a health care provider licensed pursuant to Title 40 pertaining directly to a workers' compensation claim must be provided to the insurance carrier, the employer, the employee, their attorneys, or the South Carolina Workers' Compensation Commission, within fourteen days after receipt of written request. A health care facility and a health care provider may charge a fee for the search and duplication of a medical record, but the fee may not exceed sixty-five cents per page for the first thirty pages, and fifty cents per page for all other pages, and a clerical fee for searching and handling not to exceed fifteen dollars per request plus actual postage and applicable sales tax. The facility or provider may charge a patient or the patient's representative no more than actual cost for the reproduction of an X-ray. Actual cost means the cost of materials and supplies used to duplicate the X-ray and the labor and overhead costs associated with the duplication. If a treatment facility or physician fails to send the requested

information within forty-five days of receipt of the request, the person or entity making the request may apply to the commission for an appropriate penalty payable to the commission, not to exceed two-hundred dollars.

Regulations (Chapter 67, Article 13)

67-1301. Medical Reports

A. A medical practitioner or treatment facility shall furnish upon request all medical information relevant to the employee=s complaint of injury to the claimant, the employer, the employer=s representative, or the Commission. Payment for services rendered may be withheld from any medical practitioner or treatment facility who fails to comply with a request for this information.

B. The employer=s representative shall submit to the Commission a report indicating the claimant=s final rating of permanent impairment.

67-1303. Payments for Hospital Inpatient Services

A. The Commission shall maintain a prospective payment system based on diagnosis related groups with methodology and prices established by the Commission for the payment of inpatient hospital services.

(1) Hospitals submit claims for payment to the employer or insurance carrier on the Form 14A.

(2) The Commission recognizes the current uniform billing (UB) form as its Form 14A for hospitals.

(3) The employer or insurance carrier reviewing the claim for payment shall be entitled to a copy of the applicable hospital records at no charge.

B. The Commission may review and revise the prospective payment system as needed.

C. An employer or insurance carrier may not pay, and a hospital may not accept, more than the amount set by the Commission for inpatient hospital services.

67-1304. Payments for Hospital Outpatient Services and Ambulatory Surgical Centers

A. The Commission shall develop a prospective payment system for outpatient hospital services and services rendered by ambulatory surgical centers. Until such time as the prospective payment system is operational the payments for hospital outpatient services and ambulatory surgical centers shall be set by the Commission based on a discount to the provider=s usual and customary charge.

67-1305. Medical Bill Review

A. Upon receipt of a medical claim, the employer or carrier shall review the bill for compliance with the policies and maximum payments set forth by the Commission.

(1) An employer or insurance carrier who reviews medical claims for payment must apply to the Commission for approval to review and reduce medical bills. An employer who is not an approved reviewer may solicit the services of an approved bill reviewer, but may not rely on the Commission for bill review services.

(2) In cases where the billing involves unusual or complex circumstances the bill may be sent to the Commission=s Medical Services Division for initial review.

(3) Whenever a charge is reduced to the Commission=s maximum allowable payment, the reviewer shall include on the explanation of benefits (EOB) form a statement which explains the reduction and indicates the provider=s right to appeal the reduction as outlined in subsections B and C.

B. A medical provider who disagrees, based on Commission payment policy, with a reduction may appeal the decision directly to the payer/reviewing entity.

C. If the disagreement cannot be resolved between the provider and the payer/reviewer, the matter may then be referred to the Commission=s Medical Services Division for review and resolution.

(1) A provider or reviewer may request a review by submitting to the Medical Services Division (a) a cover letter outlining the dispute and stating the requesting party=s position regarding the correct payment, (b) a copy of the bill, (c) a copy of the explanation of benefits (EOB), and (d) any supporting documentation.

(2) The Medical Services Division shall review the bill and supporting documentation, using its medical consultant as needed, and shall make a determination regarding correct payment.

(3) The decision of the Medical Services Division shall be final.

D. Any medical provider who discovers an incorrect payment within two years of the original billing date may resubmit the claim to the payer for the correct payment.

E. Any payer who discovers an overpayment made to a provider within two years of the original billing date may request a refund from that provider.

DRG Classifications and Rates

DRG	DRG DESCRIPTION	TRIMPOINTS LOW	TRIMPOINTS HIGH	DRG RATE

1	Craniotomy age > 17, except for trauma	$16,214	$41,073	$25,499
2	Craniotomy for trauma, age > 17	18,742	49,795	20,602
3	Craniotomy, 0 - 17 yrs old	12,535	30,059	19,107
4	Spinal procedures	8,925	29,952	14,290
5	Extracranial vascular procedures	9,519	17,217	12,612
6	Carpal tunnel release	4,653	8,707	6,627
7	Peripheral and cranial nerve and other nervous system procedures w/ cc	9,790	25,810	17,897
8	Peripheral and cranial nerve and other nervous system procedures w/o cc	5,677	11,344	7,464
9	Spinal disorders and injuries	5,749	21,478	11,179
10	Nervous system neoplasms w/ cc	5,518	14,612	9,449
14	Specific cerebrovascular disorders except transient ischemic attack	6,229	16,321	10,238
15	Transient ischemic attack and precerebral occlusions	4,274	8,181	5,891
18	Cranial and peripheral nerve disorders w/ cc	4,205	10,967	6,548
19	Cranial and peripheral nerve disorders w/o cc	2,544	6,742	4,170
20	Nervous system infection except viral meningitis	8,889	25,693	17,266
23	Nontraumatic stupor and coma	3,648	7,734	6,330

24	Seizure and headache, age >17 w/ cc	3,642	10,093	5,611
25	Seizure and headache, age >17 w/o cc	2,380	4,831	3,614
26	Seizure and headache, age 0-17	2,556	5,676	4,016
27	Traumatic stupor and coma, coma > 1 hour	5,852	30,660	14,916
28	Traumatic stupor and coma, < 1 hour, age > 17 w/ cc	5,317	15,353	7,580
29	Traumatic stupor and coma, < 1 hour, age > 17 w/o cc	2,639	7,317	4,112
30	Traumatic stupor and coma, < 1 hour, age 0-17	2,266	5,360	3,352
31	Concussion, age > 17 w/ cc	3,221	6,531	5,145
32	Concussion, age > 17 w/o cc	2,305	4,751	2,662
33	Concussion, age 0-17	1,966	3,290	2,676
34	Other disorders of nervous system w/ cc	5,216	14,054	8,887
35	Other disorders of nervous system w/o cc	3,364	6,517	4,776
36	Retinal procedures	$5,136	$8,257	$6,540
37	Orbital procedures	5,790	11,698	7,929
39	Lens procedures with or without vitrectomy	7,400	11,049	8,655
40	Extraocular procedures except orbit, age > 17	5,894	12,144	9,402
41	Extraocular procedures except orbit, age 0-17	6,766	10,228	8,723

42	Intraocular procedures except retina, iris and lens	5,100	8,550	7,788
43	Hyphema	1,309	2,516	1,997
44	Acute major eye infections	2,689	5,300	3,946
46	Other disorders of the eye, age > 17 w/ cc	3,009	9,976	6,163
47	Other disorders of the eye, age > 17 w/o cc	1,523	3,993	2,358
48	Other disorders of the eye, age 0-17	5,727	14,455	11,983
53	Sinus and mastoid procedures, age > 17	5,538	10,972	7,659
54	Sinus and mastoid procedures, age 0-17	5,443	8,995	7,040
55	Miscellaneous ear, nose, mouth and throat procedures	5,721	11,403	8,407
56	Rhinoplasty	5,176	9,302	6,757
58	Tonsillectomy and adenoidectomy procedure, except tonsillectomy and/or adenoidectomy only, age 0-17	4,010	6,036	4,641
62	Myringotomy with tube insertion, age 0-17	8,073	8,799	8,312
63	Other ear, nose, mouth and throat O.R. procedures	7,738	14,149	9,413
65	Dysequilibrium	2,674	5,546	3,869
69	Otitis media and upper respiratory infection, age > 17 w	2,277	4,596	3,327
70	Otitis media and upper respiratory infection, age 0-17	1,983	3,945	2,783
72	Nasal trauma and deformity	3,512	8,120	5,743

73	Other ear, nose, mouth and throat diagnoses, age > 17	2,800	5,590	4,286
74	Other ear, nose, mouth and throat diagnoses, age 0-17	1,661	2,945	2,220
75	Major chest procedures	15,272	32,508	22,484
76	Other respiratory system operating room procedures w/	10,816	24,662	17,512
77	Other respiratory system operating room procedures w/	6,214	12,088	9,358
78	Pulmonary embolism	7,546	14,401	10,506
79	Respiratory infections and inflammation, age > 17 w/ cc	8,385	20,352	14,072
81	Respiratory infections and inflammation, age 0-17	$5,731	$18,104	$11,115
82	Respiratory neoplasms	6,621	17,625	11,438
83	Major chest trauma w/ cc	4,711	9,767	7,020
84	Major chest trauma w/o cc	3,336	7,300	5,371
85	Pleural effusion w/ cc	6,076	16,250	10,246
86	Pleural effusion w/o cc	3,950	8,381	5,739
87	Pulmonary edema and respiratory failure	5,711	13,290	9,346
88	Chronic obstructive pulmonary disease	4,998	10,273	7,506
89	Simple pneumonia and pleurisy, age > 17 w/ cc	5,385	12,255	8,115
91	Simple pneumonia and pleurisy, age 0-17	3,582	8,343	4,926
92	Interstitial lung disease w/ cc	5,673	13,269	9,219

93	Interstitial lung disease w/o cc	4,849	9,856	7,307
94	Pneumothorax w/ cc	4,757	11,126	6,605
95	Pneumothorax w/o cc	2,823	6,235	5,576
96	Bronchitis and asthma, age >17 w/ cc	4,277	8,922	6,404
97	Bronchitis and asthma, age >17 w/o cc	3,322	6,463	4,692
98	Bronchitis and asthma, age 0-17	2,862	5,544	4,154
99	Respiratory signs and symptoms w/ cc	3,824	7,451	5,681
100	Respiratory signs and symptoms w/o cc	3,320	6,170	4,536
101	Other respiratory system diagnoses w/ cc	4,544	10,481	7,279
102	Other respiratory system diagnoses w/o cc	3,007	5,834	4,431
104	Cardiac valve procedures with cardiac catheter	48,598	75,794	61,037
106	Coronary bypass with cardiac catheter	33,599	48,291	39,524
107	Coronary bypass w/o cardiac catheter	25,073	34,605	27,987
108	Other cardiothoracic procedures	21,826	48,439	31,224
110	Major cardiovascular procedures w/ cc	22,085	44,846	31,895
111	Major cardiovascular procedures w/o cc	16,652	29,141	22,967
112	Percutaneous cardiovascular procedures	13,528	25,577	17,802

113	Amputation for circulatory system disorders except upp limb and toe	14,012	38,133	26,403
114	Upper limb and toe amputation for circ. system disorder	$8,697	$19,102	$14,170
116	Other permanent cardiac pacemaker implant or AICD l or generator procedure	16,999	26,893	20,965
120	Other circulatory system operating room procedures	10,077	22,317	15,908
121	Circulatory disorders with acute myocardial infarction a cardiovascular complications, discharged alive	9,105	18,268	13,627
122	Circulatory disorders with acute myocardial infarction w cardiovascular complications, discharged alive	7,024	13,603	9,907
124	Circulatory disorders except acute myocardial infarction with cardiac catheter and complex diagnosis	7,303	12,056	9,311
125	Circulatory disorders except acute myocardial infarction with cardiac catheter without complex diagnosis	6,238	9,931	7,720
127	Heart failure and shock	5,002	11,596	7,307
128	Deep vein thrombophlebitis	3,888	7,602	5,381
129	Cardiac arrest, unexplained	6,014	17,931	10,464
130	Peripheral vascular disorders w/ cc	4,636	11,270	6,351
131	Peripheral vascular disorders w/o cc	3,877	7,291	4,945
132	Atheroscerosis w/ cc	3,373	6,643	4,520
133	Atheroscerosis w/o cc	3,381	6,265	4,867

134	Hypertension	3,063	6,613	4,560
138	Cardiac arrhythmia and conduction disorders w/ cc	3,551	7,547	5,037
139	Cardiac arrhythmia and conduction disorders w/o cc	2,787	5,370	3,812
140	Angina pectoris	3,055	5,480	4,125
141	Syncope and collapse w/ cc	3,392	6,804	4,830
142	Syncope and collapse w/o cc	2,999	5,621	4,247
143	Chest pain	3,062	5,417	4,750
144	Other circulatory system disorders w/ cc	4,894	12,865	7,933
145	Other circulatory system disorders w/o cc	3,425	7,683	4,794
148	Major small and large bowel procedures w/ cc	15,765	36,060	22,874
149	Major small and large bowel procedures w/o cc	10,309	16,585	13,060
150	Peritoneal adhesiolysis w/ cc	12,248	25,844	17,926
151	Peritoneal adhesiolysis w/o cc	$7,607	$13,191	$10,363
152	Minor small and large bowel procedures w/ cc	9,745	18,109	13,287
153	Minor small and large bowel procedures w/o cc	7,911	13,431	10,252
155	Stomach, esophageal and duodenal procedures, age >1 w/o cc	8,971	13,709	11,111
156	Stomach, esophageal and duodenal procedures, age 0-	13,886	36,681	30,941

157	Anal and stomal procedures w/ cc	4,653	9,232	6,768
158	Anal and stomal procedures w/o cc	3,813	6,285	4,933
159	Hernia procedures except inguinal and femoral, age > 1 w/ cc	6,706	12,023	8,887
160	Hernia procedures except inguina1 and femoral, age > 1 w/o cc	5,217	9,844	6,690
161	Inguinal and femoral hernia procedures, age >17 w/ cc	5,507	8,714	7,104
162	Inguinal and femoral hernia procedures, age >17 w/o cc	5,150	7,140	5,580
163	Hernia procedures, age 0-17			
165	Appendectomy w/ complicated principal diagnosis w/o	7,823	13,881	9,876
169	Mouth procedures w/o cc	5,764	10,228	7,317
170	Other digestive system operating room procedures w/ c	10,462	40,273	17,899
174	Gastrointestinal hemorrhage w/ cc	4,463	9,084	6,371
175	Gastrointestinal hemorrhage w/o cc	2,963	5,382	4,064
177	Uncomplicated peptic ulcer w/ cc	4,054	8,198	5,939
181	Gastrointestinal obstruction w/o cc	2,746	5,864	3,743
182	Esophagitis, gastroenteritis and miscellaneous digestive disorders, age > 17 w/ cc	3,140	7,274	4,720
183	Esophagitis, gastroenteritis and miscellaneous digestive disorders, age > 17 w/o cc	2,753	5,630	4,110

184	Esophagitis, gastroenteritis and miscellaneous digestive disorders, age 0-17	1,744	3,578	2,699
185	Dental and oral disorders except extractions and restorations, age > 17	3,371	9,873	5,829
186	Dental and oral disorders except extractions and restorations, age 0-17	3,640	6,421	5,601
187	Dental extractions and restorations	$4,677	$7,432	$6,015
188	Other digestive system diagnoses, age > 17 w/ cc	3,963	10,585	6,538
189	Other digestive system diagnoses, age > 17 w/o cc	2,318	5,669	3,890
190	Other digestive system diagnoses, age 0-17	2,507	7,851	5,820
197	Cholecystectomy except by laparoscope with common duct exploration w/ cc	11,317	21,929	15,601
198	Cholecystectomy except by laparoscope without comm duct exploration w/o cc	7,754	12,764	10,089
204	Disorders of pancreas except malignancy	4,836	13,779	7,533
205	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis w/ cc	5,158	15,814	9,235
206	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis w/o cc	2,998	6,880	4,630
207	Disorders of the biliary tract w/ cc	4,544	10,523	7,130
209	Major joint and limb reattachment proc. of lower extre	19,757	29,955	22,689

210	Hip and femur procedures exc. major joint, age >17 w/	14,414	26,225	20,557
211	Hip and femur procedures exc. major joint, age >17 w/	10,252	15,196	11,669
213	Amputation for musculoskeletal system and connective tissue disorders	7,695	20,625	12,204
214	Back and neck procedure w/ cc	10,928	22,815	14,732
215	Back and neck procedures w/o cc	7,268	11,903	8,911
216	Biopsies of musculoskeletal system and connective tissu	9,071	22,500	16,095
217	Wound debridement and skin graft except hand, for musculoskeletal and connective tissue disorder	8,617	22,201	12,936
218	Lower extremity and humerus procedure except hip, fo femur, age > 17 w/ cc	9,490	18,761	11,772
219	Lower extremity and humerus procedure except hip, fo femur, age > 17 w/o cc	7,176	12,252	8,717
220	Lower extremity and humerus procedure except hip, fo femur, age 0-17	14,394	34,657	27,687
221	Knee procedures w/ cc	9,127	18,346	12,275
222	Knee procedures w/o cc	7,739	12,192	9,156
223	Major shoulder/elbow procedure, or other upper extre procedure w/ cc	$6,316	$9,532	$7,345
224	Major shoulder/elbow procedure, or other upper extre procedure w/o cc	6,236	9,303	7,336

225	Foot procedures	6,902	11,577	8,394
226	Soft tissue procedures w/ cc	7,372	17,482	10,809
227	Soft tissue procedures w/o cc	5,765	8,346	6,717
228	Major thumb or joint procedure, or other hand or wrist procedure w/ cc	6,580	14,666	8,846
229	Hand or wrist procedures, except major joint procedur w/o cc	4,924	8,065	5,731
230	Local excision and removal of internal fixation devices o hip and femur	5,414	11,033	6,286
231	Local excision and removal of internal fixation devices except hip and femur	6,137	10,115	7,772
232	Arthroscopy	6,484	9,572	7,660
233	Other musculoskeletal system and connective tissue operating room procedure w/ cc	11,151	25,867	19,709
234	Other musculoskeletal system and connective tissue operating room procedure w/o cc	5,653	9,887	7,024
235	Fractures of femur	4,391	11,729	5,835
236	Fractures of hip and pelvis	3,540	8,614	5,926
238	Osteomyelitis	6,695	14,073	9,496
239	Pathological fractures and musculoskeletal and connecti tissue malignancy	6,877	19,297	12,807

240	Connective tissue disorders w/ cc	5,021	18,849	8,979
242	Septic arthritis	4,746	9,288	7,623
243	Medical back problems	2,629	5,740	3,804
244	Bone diseases and specific arthropathies w/ cc	3,355	9,154	5,460
245	Bone diseases and specific arthropathies w/o cc	3,520	7,297	5,264
247	Signs and symptoms of musculoskeletal system and connective tissue	2,735	5,591	3,621
248	Tendonitis, myositis and bursitis	$2,932	$7,531	$4,437
249	Aftercare, musculoskeletal system and connective tissue	2,884	6,721	4,149
250	Fracture, sprain, strain, and dislocation of forearm, hand foot, age > 17 w/ cc	4,214	8,961	5,988
251	Fracture, sprain, strain, and dislocation of forearm, hand foot, age > 17 w/o cc	2,364	4,713	3,325
252	Fracture, sprain, strain, and dislocation of forearm, hand foot, age < 17	2,962	4,919	4,101
253	Fracture, sprain, strain, and dislocation of forearm, hand foot, age < 17 w/ cc	4,269	9,861	5,920
254	Fracture, sprain, strain, and dislocation of forearm, hand foot, age < 17 w/o cc	2,907	5,874	4,166
256	Other musculoskeletal system and connective tissue dia	2,674	5,945	4,125

263	Skin graft and/or debridmt. for skin ulcer or cellulitis w/	9,347	26,858	15,650
264	Skin graft and/or debrdmt. for skin ulcer or cellulitis w/o .	5,759	11,223	8,108
265	Skin graft and/or debridement except for skin ulcer or cellulitis w/ cc	8,120	17,069	12,117
266	Skin graft and/or debridement except for skin ulcer or cellulitis w/o cc	4,635	7,392	5,768
267	Perianal and pilonidal procedures	3,585	6,049	4,458
268	Skin, subcutaneous tissue and breast plastic procedure	5,906	11,787	7,412
269	Other skin, subcutaneous tissue and breast procedure w	7,521	18,708	11,970
270	Other skin, subcutaneous tissue & breast procedure w/	4,725	8,140	7,337
271	Skin ulcers	4,313	12,618	6,589
277	Cellulitis, age >17 w/ cc	4,082	8,829	5,086
278	Cellulitis, age >17 w/o cc	3,068	6,254	4,144
280	Trauma to the skin, subcutaneous tissue and breast, age > 17 w/ cc	3,588	8,428	5,775
281	Trauma to the skin, subcutaneous tissue and breast, age > 17 w/o cc	2,394	4,666	3,276
282	Trauma to the skin, subcutaneous tissue and breast, age 0 - 17	2,504	5,223	3,901
283	Minor skin disorders w/ cc	$3,289	$7,313	$6,048

284	Minor skin disorders w/o cc	1,936	4,070	2,847
285	Amputation of lower limb for endocrine, nutrition, and metabolism disorders	10,099	26,371	18,724
287	Skin grafts and wound debridement for endocrine, nutrition and metabolism disorders	7,197	16,863	10,158
294	Diabetes, age > 35	3,076	7,738	4,669
295	Diabetes, age < 35	2,744	6,506	4,103
296	Nutritional and miscellaneous metabolic disorders, age > 17, w/ cc	3,724	10,966	6,094
297	Nutritional and miscellaneous metabolic disorders, age > 17, w/o cc	2,205	4,936	3,269
305	Kidney, ureter and major bladder procedures for neopl w/o cc	6,833	11,346	8,926
308	Minor bladder procedures w/ cc	6,913	13,679	9,794
310	Transurethral procedures w/ cc	6,016	10,304	7,041
311	Transurethral procedures w/o cc	5,076	7,350	5,948
313	Urethral procedures, age > 17 w/o cc	5,214	8,097	5,737
315	Other kidney or urinary tract operating room procedure	10,026	21,840	14,919
320	Kidney and urinary tract infections, age > 17 w/ cc	3,556	8,174	5,031
321	Kidney and urinary tract infections, age > 17 w/o cc	2,867	5,441	3,976

322	Kidney and urinary tract infections, age 0 - 17	2,706	4,734	3,446
323	Urinary stones w/ cc and/or ESW lithotripsy	3,408	8,395	6,044
324	Urinary stones w/o cc	1,787	4,113	2,766
325	Kidney and urinary tract signs and symptoms, age >17	2,841	6,157	4,087
326	Kidney and urinary tract signs and symptoms, age >17	2,263	5,156	3,780
327	Kidney and urinary tract signs and symptoms, age 0 - 1	1,275	2,037	1,734
331	Other kidney and urinary tract diagnoses, age > 17 w/ c	4,182	10,069	6,942
332	Other kidney and urinary tract diagnoses, age > 17 w/o	2,506	5,716	4,005
333	Other kidney and urinary tract diagnoses, age 0 - 17	2,453	5,943	5,171
336	Transurethral prostatectomy w/ cc	5,051	8,609	6,328
337	Transurethral prostatectomy w/o cc	$4,601	$6,551	$5,443
339	Testes procedures, non-malignancy, age > 17	4,440	7,531	5,550
350	Inflammation of the male reproductive system	3,203	6,389	4,615
358	Uterine and adnexa procedure non-malignancy w/ cc	6,732	10,665	8,032
359	Uterine and adnexa procedure for non-malignancy w/o	5,904	8,266	6,880
360	Vagina, cervix and vulva procedures	5,341	8,176	6,554
392	Splenectomy, age > 17	10,928	22,347	16,327
393	Splenectomy, age 0 - 17	10,137	16,689	14,255

394	Other operating procedures of the blood and blood forming organs	6,402	17,325	10,774
395	Red blood cell disorders, age > 17	4,496	11,237	7,373
396	Red blood cell disorders, age 0 - 17	4,203	10,038	6,827
397	Coagulation disorders	5,416	18,368	12,436
398	Reticuloendothelial and immunity disorders w/ cc	6,859	19,433	10,649
399	Reticuloendothelial and immunity disorders w/o cc	4,103	8,625	6,286
403	Lymphoma and non-acute leukemia w/ cc	9,994	39,578	18,087
415	Operating room procedure for infectious and parasitic d	8,703	26,899	14,176
416	Septicemia, age > 17	7,205	20,339	12,324
417	Septicemia, age 0 - 17	3,981	18,481	7,076
418	Postoperative and post-traumatic infections	3,885	7,519	5,730
419	Fever of unknown origin, age > 17 w/ cc	4,578	12,595	6,596
422	Viral illness and fever of unknown origin, age 0 - 17	2,172	4,737	2,999
423	Other infectious and parasitic disease diagnoses	4,549	12,842	7,597
425	Acute adjustment reaction and disturbances of psychos dysfunction	3,018	6,978	4,801
426	Depressive neuroses	2,772	6,729	4,547

427	Neuroses except depressive	2,397	6,163	3,986
428	Disorders of personality and impulse control	3,401	8,301	5,622
429	Organic disturbances and mental retardation	4,545	10,234	7,198
430	Psychoses		$956.00 Per Day	
439	Skin grafts for injuries	$6,173	$14,448	$10,968
440	Wound debridements for injuries	6,820	19,598	10,287
441	Hand procedures for injuries	5,360	10,970	6,919
442	Other operating room procedures for injuries w/ cc	9,216	30,658	9,749
443	Other operating room procedures for injuries w/o cc	6,179	11,519	8,006
444	Traumatic injury, age > 17 w/ cc	3,319	7,370	5,563
445	Traumatic injury, age > 17 w/o cc	2,371	5,248	3,654
446	Traumatic injury, age 0 - 17	1,941	3,627	2,453
447	Allergic reactions, age > 17	1,875	5,572	2,819
448	Allergic reactions, age 0 - 17	1,737	3,700	2,477
449	Poisoning and toxic effects of drugs, age > 17 w/ cc	3,478	8,257	5,305
450	Poisoning and toxic effects of drugs, age > 17 w/o cc	2,183	4,103	2,821
451	Poisoning and toxic effects of drugs, age 0 - 17	3,589	8,504	4,746
452	Complications of treatment w/ cc	3,417	10,227	5,288

453	Complications of treatment w/o cc	2,079	4,950	3,503
454	Other injury, poisoning and toxic effect diagnosis w/ cc	3,336	7,882	5,365
455	Other injury, poisoning and toxic effect diagnosis w/o cc	2,466	4,017	3,105
456	Burns, transferred to another acute care facility	4,864	12,347	8,019
458	Non-extensive burns w/ skin graft	6,954	29,425	13,707
459	Non-extensive burns w/ wound debridement or other operating room procedure	4,026	8,757	6,741
460	Non-extensive burns w/o operating room procedure	2,245	6,367	3,824
461	Operating room procedure w/ diagnosis of other contac with health services	7,269	31,837	20,700
462	Rehabilitation		$796.00 Per Day	
464	Signs and symptoms w/o cc	3,130	7,253	4,836
466	Aftercare w/o history of malignancy as secondary diagn	1,515	4,032	2,502
467	Other factors influencing health status	4,204	10,756	8,170
468	Extensive operating room procedure unrelated to princi Diagnosis	10,812	35,236	11,672
471	Bilateral or major joint procedure of lower extremity	27,246	39,178	31,871
472	Extensive burns w/ operating room procedure	$55,630	$78,680	$66,667
475	Respiratory system diagnosis w/ ventilator support	19,787	59,994	29,709

477	Non-extensive operating room proc. unrelated to prin.	5,380	16,069	8,463
478	Other vascular procedures w/ cc	12,132	28,264	18,338
479	Other vascular procedures w/o cc	8,703	17,625	12,567
480	Liver transplant	62,257	129,988	92,795
482	Tracheostomy for face, mouth and neck diagnoses	17,871	37,080	24,668
483	Tracheostomy except for face, mouth and neck diagnos	82,474	204,340	179,929
484	Craniotomy for multiple significant trauma	41,458	77,971	56,269
485	Limb reattachment, hip and femur procedure for multipl significant trauma	28,679	62,633	46,850
486	Other O.R. procedure for multiple significant trauma	23,858	69,560	40,645
487	Other multiple significant trauma	7,264	52,466	17,600
491	Major joint and limb reattachment procedures of upper Extremity	11,120	16,928	13,975
495	Lung transplant	72,395	136,770	115,498

How do you convert DRG's not found in the Hospital and Ambulatory Surgical Center Payment Manual?
(Effective July 1.1997)
DRG 496=DRG 215
DRG 497=DRG 214
DRG 498=DRG 215
DRG 499=DRG 214
DRG 500=DRG 215
DRG 501=DRG 221

DRG 502=DRG 242
DRG 503=DRG 222
DRG 504=DRG 458
DRG 505=DRG 460
DRG 506=DRG 458
DRG 507=DRG 458
DRG 508=DRG 460
DRG 509=DRG 460
DRG 510=DRG 460
DRG 511=DRG 460